



Office of Employer and Member Health Services  
P.O. Box 942714  
Sacramento, CA 94229-2714  
(888) CalPERS (225-7377)  
TDD - (916) 795-3240  
FAX (916) 795-1277

**MEDICAL REPORT for the CalPERS DISABLED DEPENDENT BENEFIT**

**COMPLETE ALL ITEMS. INCOMPLETE FORMS WILL BE RETURNED CAUSING DELAY IN BENEFITS.**

<b>MEMBER PART A: THE MEMBER IS TO COMPLETE THE INFORMATION IN PART A:</b> <b>MEMBER INFORMATION</b> <b>NAME:</b> _____ <b>SOCIAL SECURITY NUMBER (SSN)</b> _____ <b>ADDRESS:</b> _____ <b>TELEPHONE ( )</b> _____		<b>DEPENDENT INFORMATION</b> <b>NAME:</b> _____ <b>SSN</b> _____ <b>ADDRESS:</b> _____ <b>DATE OF BIRTH:</b> _____												
<b>PART B: DEPENDENT AUTHORIZATION:</b> <i>The <b>dependent</b>, or person authorized to act in his or her behalf, is to complete the information requested in PART B prior to giving the form to the physician for completion:</i>  I hereby authorize my attending physician _____ to furnish and disclose all facts concerning my disability that are within his or her knowledge and to allow inspection, and provide copies, of any medical records concerning my disability that are under his or her control. This authorization shall be valid for a period of one year from the date of my signature or the effective date of this claim, whichever is later. I agree that a photocopy of this authorization shall be as valid as an original. I understand that if I do not sign this authorization, or if I revoke or modify it, CalPERS may not be able to determine my eligibility as a disabled dependent and that my request may be denied. I also understand that CalPERS will keep confidential the information which is provided pursuant to this authorization, and that it will be used solely to determine and act upon my request for this benefit.  _____ Signature of Dependent <b>OR</b> _____ Date Signed _____  _____ Person authorized to act on his/her behalf _____ Relationship to the dependent _____														
<b>PHYSICIAN PART C:</b> <i>The <b>physician</b> is to complete all requested information in PARTS C and D. All responses must be legible. Mail this completed form to CalPERS at the address found at the top of this page.</i> <b>Please DO NOT send information copied directly from the patient's medical record at this time.</b>  <b>Dear Doctor:</b> The patient requests you to complete this <b>Medical Report</b> form. It will assist CalPERS in processing his or her claim for health insurance as a disabled dependent under his or her parent's or guardian's health plan. By providing the medical information promptly, you will help the patient expedite the claims process.														
<table border="1"><thead><tr><th colspan="2"><b>Medical Report</b></th></tr></thead><tbody><tr><td>1.</td><td>I attended the patient for the current disabling medical problem or condition from _____ to _____; At intervals of _____. I last examined the patient on _____.</td></tr><tr><td>2.</td><td>Medical History (related to disability): Date of Disability Onset: _____</td></tr><tr><td>3.</td><td>Diagnosis (REQUIRED): _____ ICD-9 Disease Code, Primary (Required) : _____ ICD-9 Disease Code(s), Secondary : _____ DSM IV Code(s) (if any) : _____</td></tr><tr><td>4.</td><td>Objective Clinical Findings/Detailed Statement of Symptoms: (see page 2, Items 6 and 7 for additional findings)</td></tr><tr><td>5.</td><td>Current Treatment(s) and /or Medication(s) (rendered to the patient for this disability):  <input type="checkbox"/> The patient is not currently receiving treatment(s) and/or medications for this disability. (Check if applicable.)</td></tr></tbody></table>			<b>Medical Report</b>		1.	I attended the patient for the current disabling medical problem or condition from _____ to _____; At intervals of _____. I last examined the patient on _____.	2.	Medical History (related to disability): Date of Disability Onset: _____	3.	Diagnosis (REQUIRED): _____ ICD-9 Disease Code, Primary (Required) : _____ ICD-9 Disease Code(s), Secondary : _____ DSM IV Code(s) (if any) : _____	4.	Objective Clinical Findings/Detailed Statement of Symptoms: (see page 2, Items 6 and 7 for additional findings)	5.	Current Treatment(s) and /or Medication(s) (rendered to the patient for this disability):  <input type="checkbox"/> The patient is not currently receiving treatment(s) and/or medications for this disability. (Check if applicable.)
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(See page 2 of this for additional required information.)

MEMBER: \_\_\_\_\_  
SSN: \_\_\_\_\_

DEPENDENT NAME: \_\_\_\_\_  
SSN: \_\_\_\_\_

<b>Medical Report</b>																									
<b>6</b>	<b>Functional Assessment of Activities of Daily Living (ADLS):</b> Indicate the patient's degree of physical or mental disability in the following ADLs using a scale of 1 to 10. One (1) indicates the ADL is not affected by the patient's disability. A ten (10) indicates the patient is completely disabled in this ADL skill or ability. These functional disabilities limit the patient's capacity for self support. <table><thead><tr><th><b>Mobility Skills</b></th><th><b>Self-Care Skills</b></th><th><b>Sensory Skills</b></th><th><b>Cognitive Skills</b></th></tr></thead><tbody><tr><td>____ walking</td><td>____ feeding</td><td>____ hearing</td><td>____ judgment</td></tr><tr><td>____ sitting</td><td>____ bathing</td><td>____ seeing</td><td>____ memory</td></tr><tr><td>____ standing</td><td>____ toileting</td><td>____ speech</td><td>____ planning/follow through</td></tr><tr><td>____ lifting</td><td>____ dressing</td><td>____ touch</td><td>____ thinking/processing information</td></tr><tr><td>____ bending</td><td></td><td></td><td></td></tr></tbody></table>	<b>Mobility Skills</b>	<b>Self-Care Skills</b>	<b>Sensory Skills</b>	<b>Cognitive Skills</b>	____ walking	____ feeding	____ hearing	____ judgment	____ sitting	____ bathing	____ seeing	____ memory	____ standing	____ toileting	____ speech	____ planning/follow through	____ lifting	____ dressing	____ touch	____ thinking/processing information	____ bending			
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<b>7.</b>	<b>Psychological / Psychiatric Assessment:</b> List the specific psychological / psychiatric symptoms or behaviors, if any, that affect the patient's ADLs and limit his or her capacity to be self-supporting:																								

**PART D: Medical Certification of Disability and Incapacity of Self Support:** For purposes of this benefit, a CalPERS member can retain his or her eligibility for health benefits as a family member if he or she is unmarried and incapable of self-support (i.e., not capable of engaging in any substantial gainful activity) due to physical or mental disability which existed continuously prior to becoming 23 years of age.

- Based upon your examination, does the patient currently have a physically or mentally disabling injury, illness or condition?  
\_\_\_\_ NO, the patient does NOT have a physically or mentally disabling injury, illness or condition.  
\_\_\_\_ YES (Please answer Question 2.)
- In your medical or psychiatric opinion, please select **A**, **B**, or **C**:  
\_\_\_\_ **A.** The patient's current disability DOES NOT render him or her incapable of self-support.  
\_\_\_\_ **B.** The patient's current disability DOES render him or her incapable of self-support, but the disability should resolve or improve sufficiently for the patient to be capable of self-support by \_\_\_\_\_.  
(projected DATE—mm / yy)  
*If the condition is likely to improve or resolve, make SOME "estimate" of when this will occur.*  
*Please DO NOT leave the DATE blank. Answers such as "indefinite" or don't know" will not suffice.*  
\_\_\_\_ **C.** The patient's current disability is of a permanent or extended duration and, consequently, the patient is not and will not be capable of self support within the foreseeable future (e.g., more than 5 years).

I certify that, based upon my examination of the patient, the above statements truly describe the patient's disability and his or her capability of self support, and that I am a \_\_\_\_\_,  
(Type of Physician) (Specialty, if any)

licensed to practice by the State of \_\_\_\_\_.

PRINT, TYPE or STAMP PHYSICIAN'S NAME AS SHOWN ON LICENSE and HIS OR HER ADDRESS, TELEPHONE AND FAX NUMBERS:

\_\_\_\_\_  
PHYSICIAN'S NAME AS SHOWN ON LICENSE

\_\_\_\_\_  
ORIGINAL SIGNATURE OF ATTENDING PHYSICIAN

\_\_\_\_\_  
LOCAL ADDRESS

\_\_\_\_\_  
STATE LICENSE NUMBER

\_\_\_\_\_  
CITY STATE

(\_\_\_\_\_)\_\_\_\_\_  
TELEPHONE NUMBER

\_\_\_\_\_  
DATE

(\_\_\_\_\_)\_\_\_\_\_  
FAX NUMBER

**PART E: CalPERS USE ONLY:**

\_\_\_\_ Claim approved for enrollment through \_\_\_\_\_  
DATE (for next review)

\_\_\_\_\_  
REVIEWED BY

\_\_\_\_ Claim rejected.

\_\_\_\_\_  
DATE

## **PRIVACY INFORMATION**

The Information Practices Act of 1977 and the Federal Privacy Act require the California Public Employees' Retirement System (CalPERS) to provide the following information to individuals who are asked to supply information. The information requested is collected pursuant to the Government Code Sections (20000. et seq.) and will be used for administration of the Board's duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to supply the information may result in the System being unable to perform its functions regarding your status. Portions of this information may be transferred to other governmental agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

You have the right to review your membership files maintained by the System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Practices Act Coordinator, CalPERS, PO Box 942702, Sacramento, CA 94229-2702.

Section 7(b), of the Privacy Act of 1974 (Public Law 93—579) requires that any federal, state, or local governmental agency which requests an individual to disclose his Social Security account number shall inform that individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it.

The Office of Employer and Member Health Services of the California Public Employees' Retirement System requests each enrollee's Social Security account number on a voluntary basis. However, it should be noted that due to the use of Social Security account numbers by other agencies for identification purposes, the Office of Employer and Member Health Services may be unable to verify eligibility for benefits without the Social Security account number.

The Office of Employer and Member Health Services of the California Public Employees' Retirement System uses Social Security account numbers for the following purposes:

1. Enrollee identification for eligibility processing and eligibility verification
2. Payroll deduction and state contribution for state employees
3. Billing of contracting agencies for employee and employer contributions
4. Reports to the California Public Employees' Retirement System and other state agencies
5. Coordination of benefits among carriers
6. Resolve member appeals/complaints/grievances with health plan carriers